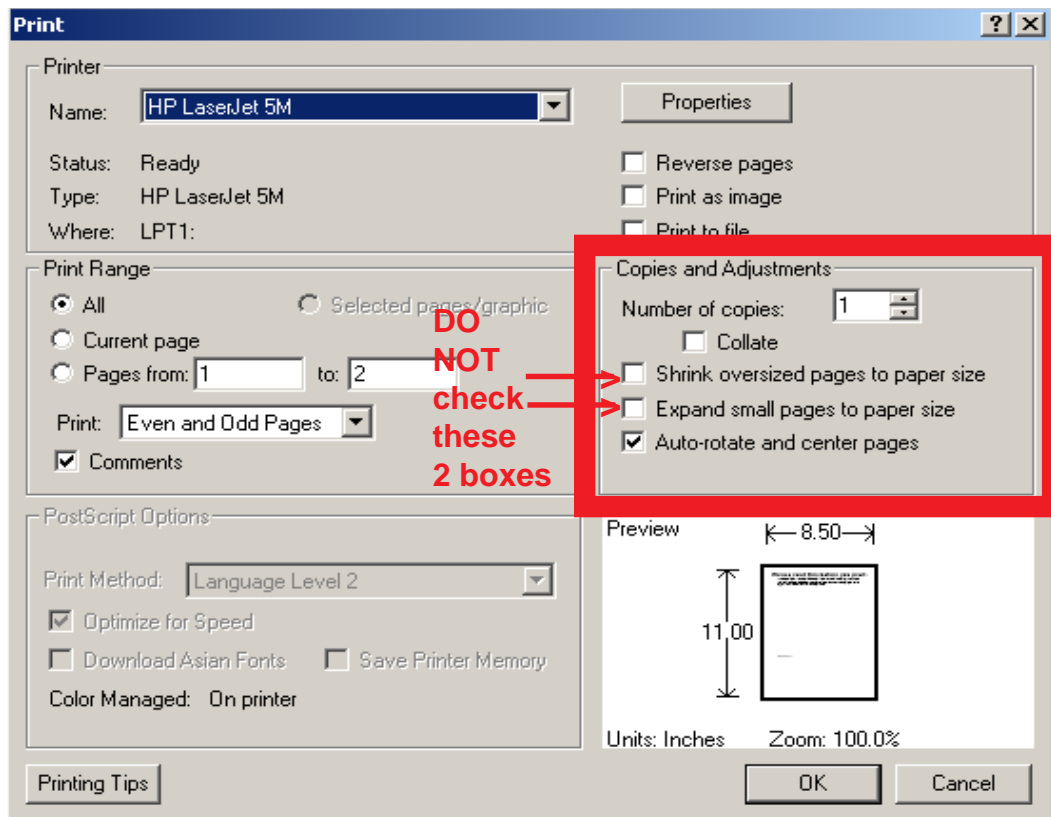


Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand boxes.



(This page intentionally left blank.)



Washington State Department of

Health

Health Professions Quality Assurance Division

P.O. Box 1099

Olympia, WA 98507-1099

A. Contents:

Registered Nurse by Examination Packet

1. 669-242 .. Contents List/SSN Information/Deposit Slip 1 page
2. 669-243 .. Instructions for NCLEX-RN 2 pages
3. 669-002 .. Application for License By Examination or Endorsement 4 pages
4. 669-222 .. Certificate of Completion of RN Program 1 page

B. Important Social Security Number Information:

- * Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.
- * Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099.**



Cut along this line and return the form below with your completed application and fees.



Registered Nurse (Examination)

DEPOSIT SLIP

NAME (Please Print)

Revenue Section

P.O. Box 1099

Olympia, Washington 98507-1099

DATE

Please note amount enclosed, and return with your application.

\$

☐ Check

☐ Money Order

DOH 669-242 (REV 10/2003)

1F 0258010000 00099

(This page intentionally left blank.)



Washington State Department of
Health
Washington State Nursing Commission
P.O. Box 1099
Olympia, WA 98507-1099

Instructions For NCLEX Registered Nurse

Washington State Application:

1. Complete the application in full and sign the 'Applicant Attestation.'
2. Attach a recent 2"x2" passport size picture of yourself you have signed on the back.
3. \$65 fee (check or money order) payable to DOH (Department of Health). This fee is not refundable.
4. Sign the attestation portion of the application for the seven (7) hours of HIV/AIDS education if you have had it within your nursing program.

Mail the above listed items to: Department of Health
Nursing Commission
P.O. Box 1099
Olympia, WA 98507-1099

NCLEX Candidate Bulletin:

5. Read the Candidate Bulletin and follow the instructions. Send the fee and the completed registration form in the supplied pre-addressed envelope as directed. The Candidate Bulletin can be downloaded from <http://www.ncsbn.org>.

Certificate of Completion:

6. Have your school of nursing complete, sign, date, and return your 'certificate of program completion' form to the Nursing Commission Office as soon as possible after you have completed your program. Have your school mail your transcript with degree posted to the Nursing Commission.
7. If you have had a name change, be sure the school and the Nursing Commission have the same name for you.

Time Frames:

8. From the time you mail your application for license by exam to the Nursing Commission Office and it is received, is usually two weeks (14 days). We will not be able to assist you prior to receiving your application, so please allow that time to lapse first before calling with questions.
9. Carefully read and maintain your Candidate Bulletin. It contains valuable information and telephone numbers.
10. We normally receive results two weeks following your exam. Once they are received in the Nursing Commission Office they are processed and mailed to the candidate. Please allow four weeks from the time you test and the time you receive your results in the mail. Your license is mailed with your 'pass' results.
11. Should you fail, you will be notified by mail, with instructions on how to reapply with the testing company. There is a mandatory 91 day wait between tests.
12. **WAC 246-840-070 Failures—Repeat examination. (3) Candidates who fail the examination will be permitted to retake the examination three times within the two-year period from the month of completion of the nursing program.**
13. If you have questions or concerns, please call 360-236-4706.

HIV/AIDS Information

AIDS Education Requirements for Health Related Professions

All health related professions under the disciplinary authority of the Uniform Disciplinary Act (RCW 18.130) are affected. This requirement went into effect January, 1989.

The topics that must be covered by this requirement are: ***etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality and psychosocial issues to include special population considerations***. The course must be seven (7) hours or more in length.

If you completed your nursing program in 1989 or later and completed this requirement in the nursing courses, or a CE course, etc., after this time, you may complete the attestation portion of your application which specifies you have met this requirement. Keep documentation of completion for future reference. You may need to show proof to an employer.

If you feel you have not met this requirement, or you cannot document that you have, you can meet this requirement through a correspondence course or a community college. A partial listing of available offerings follows:

Robert D. Anderson Publishing Company
1-800-532-2332

Intercollegiate Center for Nursing Education
(509) 324-7356

University of Washington
(206)543-1047

Impact Inc.
(206) 284-3865

Department of Health
AIDS Information Hot Line
1-800-272-2437
Website: www.doh.wa.gov/cfh/hiv.htm Select "prevention"

New York State Nurses Association
(518) 782-9400
E-mail: info@nysna.org
Website: <http://www.nysna.org>



Health Professions Quality Assurance Division
P.O. Box 1099
Olympia, WA 98507-1099

FOR OFFICE USE ONLY		
LICENSE DATE	CANDIDATE NUMBER	VALIDATION NUMBER
SCHOOL CODE	GRADUATE DATE	
<input type="checkbox"/> AIDS <input type="checkbox"/> Cert <input type="checkbox"/> MBOS <input type="checkbox"/> Verif (Foreign) <input type="checkbox"/> Photo <input type="checkbox"/> Scripts <input type="checkbox"/> CGFNS <input type="checkbox"/> TOEFL <input type="checkbox"/> Active License) <input type="checkbox"/> Other		

LICENSE #

Application For License By Examination Or Endorsement

☐ **Registered Nurse**

☐ Examination ☐ Endorsement

☐ **Licensed Practical Nurse**

☐ Examination ☐ Endorsement

Please Type or Print Clearly—Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application. All applications must be accompanied by applicable fee which is non-refundable. Photo copied applications are not accepted. Make remittance payable to the Department of Health.

1. Demographic Information

APPLICANT'S NAME		LAST	FIRST	MIDDLE INITIAL
MAILING ADDRESS				
CITY		STATE	ZIP	COUNTY
TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING NORMAL BUSINESS HOURS.) ()		RESIDENCE TELEPHONE ()	SOCIAL SECURITY NUMBER (Required for license under 42 USC 666 and Chapter 2.23 RCW) — —	

GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	BIRTHDATE (MO/DATE/YR)	PLACE OF BIRTH
Have you ever been known under any other name(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, list		
2. Education		
High school graduate? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If no, GED? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Attach Current Photograph Here.
Indicate Date Taken and Sign in Ink Across Bottom of the Photo.
NOTE: Photograph **Must** Be:

1. Original, not a photocopy
2. No larger than 2" X 2"
3. Taken within one year of application
4. Close up, front view—not profile
5. Instant Polaroid Photographs **not** acceptable

INSTITUTION	NAME	LOCATION	DATE ENTERED	DATE COMPLETED	DIP/DEGREE GRANTED
COLLEGE OR UNIVERSITY					
COLLEGE OR UNIVERSITY					
COLLEGE OR UNIVERSITY					
COLLEGE OR UNIVERSITY					

3. AIDS Education and Training Attestation

I certify I have completed the minimum of seven (7) hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS	DATE
----------------------	------

4. Personal Data Questions

YES NO

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐
- “Medical Condition”** includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.
- 1a. If you answered “yes” to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).
- 1b. If you answered “yes” to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.
- (If you answered “yes” to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in “1b” so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)
2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐
- “Currently”** means recently enough so that the use of drugs may have an ongoing impact on one’s functioning as a licensee, and includes at least the past two years.
- “Chemical substances”** includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber’s direction, as well as those used illegally.
3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐
4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐
- “Currently”** means recently enough so that the use of drugs may have an ongoing impact on one’s functioning as a licensee, and includes at least the past two years.
- “Illegal use of controlled substances”** means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.
- Note:** If you answer “yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders.
5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:
- a. the use or distribution of controlled substances or legend drugs? ☐ ☐
- b. a charge of a sex offense? ☐ ☐
- c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving) ☐ ☐
6. Have you ever been found in any civil, administrative or criminal proceedings to have:
- a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself? ☐ ☐
- b. committed any act involving moral turpitude, dishonesty or corruption? ☐ ☐
- c. violated any state or federal law or rule regulating the practice of a health care professional? ☐ ☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If “yes”, explain and provide copies of all judgments, decisions, and agreements. ☐ ☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority? ☐ ☐
9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession? ☐ ☐

5. Previous Licensure

List all states where any health care licenses are or were held. Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current.

STATE/JURISDICTION	PROFESSION	LICENSE TYPE	LICENSE		METHOD OF LICENSURE
			YEAR ISSUED	NUMBER	

6. Licensure In Other State(s) Or Country(ies)

List all states/countries you have held an RN or an LPN license in. List these licenses in the order they were issued to you (1st, 2nd, 3rd, etc.)

STATE/COUNTRY	CHECK ONE		CURRENT EXPIRATION DATE
	AS RN	AS LPN	

State or **country** in which originally licensed by examination. _____

Year license first issued _____ as an ☐ RN ☐ LPN

Have you taken the State Board Test Pool Examination (SBTPE) or NCLEX in the United States? ☐ Yes ☐ No

If yes, state _____ as an ☐ RN ☐ LPN

Have you ever applied for licensure in Washington prior to this application? ☐ Yes ☐ No

If yes, under the name of _____ as an ☐ RN ☐ LPN Approximate date _____

7. Applicant's Attestation

I, _____, certify that I am the person described and identified in
NAME OF APPLICANT

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

SIGNATURE OF APPLICANT

DATE

Official Use Only

Washington State Records Center

Certificate of Completion of RN Program **(to be completed AFTER program completion)**

I certify that the individual listed below **HAS** completed all requirements for the degree/diploma for the approved Registered Nurse program as outlined in WAC 246-840-575. I understand that my signature on this form will allow this individual to sit for the registered nurse licensure examination. **An official transcript with the degree/diploma posted will follow as soon as it is available.**

LAST NAME OF GRADUATE	
FIRST NAME	MIDDLE NAME/INITIAL
DATE OF BIRTH	SOCIAL SECURITY NUMBER
DATE OF PROGRAM COMPLETION	

Signature of Authorized Person

Title

Name of School of Nursing

School

Seal

Dated this _____ day of _____, 2 _____

An Official Transcript is attached or will follow as soon as possible.

Please send completed form to:

Washington Nursing Commission
PO Box 47864
Olympia, WA 98504-7864